

Assessing Stakeholder Opinions of Medical Review of Impaired Drivers and Fitness to Drive: Recommendations for Massachusetts

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EXECUTIVE SUMMARY

Introduction

Driving is the main mode of travel for Americans age 65 and older, and although older adults are generally found to be safe drivers, aging often brings about functional limitations and an increase in medications that can impede safe driving and fitness to drive (Rosenbloom, 2003; Kissinger, 2008; Adler & Silverstein, 2008). Effective licensing policies and Medical Advisory Board practices are critical components in identifying medically at-risk drivers and may even have a role in the transition to alternative transportation options; yet, states vary greatly in their approach to licensing and renewal practices and in the utilization, composition, and function of Medical Advisory Boards (MAB).

For many of the policies and practices, there is limited or no clear evidence about their effectiveness. Thus, seeking the opinions of the stakeholders most closely involved with these issues through their professional and clinical practice experiences was a starting point for understanding where more evidence-based data are needed or where current practice is supported.

Research Objectives

The objective of this study was to assess stakeholder opinions on current and future directions for Massachusetts in terms of strengthening the Medical Advisory Board and Registry of Motor Vehicles activities regarding medically at-risk drivers.

Methodology

This study was conducted under the auspices of an Aging and Social Policy Capstone Seminar at the University of Massachusetts Boston, College of Public and Community Service, during Spring 2009. Data were collected via in-depth interviews covering the following topics: immunity for reporting at-risk drivers; mandatory versus voluntary reporting practices; confidentiality for reporters; licensing and renewal practices; vision requirements; Registry of Motor Vehicles counter personnel training; Medical Advisory Board role, composition, and activities; and transition to mobility options.

A total of 44 stakeholders in driver safety were identified as potential participants in the research project. The overall response rate was 52% (23) of stakeholders, with representatives from the state legislature, government agencies, advocacy organizations, the licensing authority, medical communities, driving assessment centers, mobility planners, academic communities, and law enforcement.

Results

The results are presented by categories discussed during the interviews. Within these categories, the question is presented along with totaled responses to the closed-ended questions and selected excerpts from the open-ended questions.

Immunity for Reporters

The interviews began by presenting information on the current status of immunity for reporters in Massachusetts and in other states. Currently, there is no immunity for physician reporting of at-risk drivers in Massachusetts. Stakeholders were asked: *“Which of the following statements best describes your view on the current practices in Massachusetts regarding immunity for physician reporting?”* Almost all respondents (91%) stated that Massachusetts should provide immunity to physicians who, in good faith, report patients to the licensing authority whom they consider at-risk for unsafe driving. Respondents were then asked if any others should be granted immunity for reporting at-risk drivers to the licensing authority. The following additional categories of reporters were noted: optometrist/ophthalmologist (78%); nurses (70%); occupational therapists (65%); social workers (57%); other allied health professionals (52%); and family (26%).

Mandatory versus Voluntary Reporting Practices by Physicians

The next section asked respondents their opinions on mandatory versus voluntary reporting practices by physicians. Fifty-six percent agreed with current practices of voluntary reporting in Massachusetts. Some respondents had mixed opinions as illustrated by the following responses, *“I think that [the] voluntary or mandatory issue needs to be looked at. While I don’t know whether it’s an either or, Massachusetts should be voluntary or mandatory, I think we should [be] reviewing that because for someone to be an unsafe driver and for someone to report them need[s] to be better defined in Massachusetts”* (Advocacy Group). Another respondent stated, *“I think our current practice would be strengthened by giving physicians immunity along with voluntary reporting. I think immunity along with voluntary reporting is sufficient”* (Legislator/Legal Aide).

Confidentiality for Reporting

When asked about their views on the current practice in Massachusetts that does not grant confidentiality for reporters, 65% of respondents did not agree with this practice. Respondents indicated that the following categories of reporters should be ensured confidentiality: Other Allied Health Professionals (52%); Optometrists/Ophthalmologists (48%); Occupational Therapists (44%); Social Workers (39%); and Family (30%). One respondent offered, *“People will be more likely to report if there is confidentiality”* (Legislator/Legal Aide).

Licensing and Renewal Policies

Eighty-three percent of the 23 respondents did not agree with the licensing renewal practice in Massachusetts that allows individuals to go up to ten years without in-person license renewal. Most respondents advocated for more frequent in-person renewal and one respondent added, *“Everyone should be tested. It’s not a function of old age. In-person renewal is more effective”* (Medical Professional).

The current licensing renewal form for Massachusetts asks drivers to self-report if they have medical conditions or take medications that may interfere with safe driving, but it does not ask about specific conditions or medications. Respondents were asked if they

agreed with these current practices regarding self-reporting of medical conditions: 61% did not agree. Some of the responses given include: “No, the checklist [such as in Maine] would be a better idea, should be more than [an] open-ended question...” (Advocacy Group) and “It is not the individual’s role to reveal what their limitations are, but the system should identify. The form is impossible to fill out; it is confusing and terrible” (Advocacy Group).

When asked their opinions on the current licensing renewal practice in Massachusetts regarding the lack of an accelerated renewal provision, 61% did not agree with current practices. Those 14 respondents who did not agree were then asked which factors they thought might warrant accelerated renewal: 57% were in favor of using an individual’s crash history; 39% were in favor of using citations/infractions history; 35% were in favor of using medical conditions; 30% were in favor of medical certification of driver fitness; and only 22% were in favor of age as a factor in accelerated renewal. Furthermore, all respondents were asked if they agree with current practices specifically in Massachusetts prohibiting age-triggered testing. Over half of all respondents (57%) agreed with prohibiting age-triggered testing.

Vision Testing Requirement: Every Ten Years

The next section of the interview discussed vision requirements and asked respondents if they agree with the current licensing renewal policies that allow drivers to go without a vision test for 10 years. Of the total 23 respondents, 20 did not agree with the current practice.

Registry of Motor Vehicles Counter Personnel Training

The next issue discussed with respondents was whether or not there was a need for specialized training of licensing authority counter personnel to recognize “red flags” or indicators where an applicant for licensing or renewal should be referred for further assessment. Sixty-one percent disagreed with the current practice in Massachusetts that does not provide training to Registry of Motor Vehicles counter personnel.

Medical Advisory Boards

After being presented with information on the composition, function, and current practices of the Massachusetts Medical Advisory Board (MAB) as well as advisory boards in other states, respondents were asked their opinions on these issues. When asked about the current practices specifically related to the Massachusetts MAB, 78% disagreed with these practices. In regards to the composition of the Massachusetts MAB, 87% were not satisfied with the current composition. Those 20 respondents indicated that the following additional professionals should be considered for appointment to the Massachusetts MAB: a certified driver rehabilitation specialist/occupational therapist (65%), a geriatrician (50%), and a gerontologist (45%). Other professionals that were suggested include psychiatrist/psychologist, neurologist, neuropsychologist, optometrist/ophthalmologist, vision therapist, specialized physician, legal representative, and nurse.

Finally, 87% of respondents were not satisfied with the current function of the MAB. Of these (20 respondents), 60% recommended meeting on a regular basis as a way to strengthen the Massachusetts MAB; 55% supported a more direct involvement with review of impaired driver reports; and 30% supported a change from the current voluntary status to offering a stipend or honorarium. One respondent stated:

Now, I believe that the medical review board in Massachusetts is similar to the professional review board of Massachusetts and they're a policy-making board. So I guess if you were thinking of strengthening the medical review board you would want to look at strengthening the rest of the board. As a policy person, I would be much more interested in this broader view rather than specifically the medical review board (Advocacy Group).

Transition to Mobility Options

When asked whether the Massachusetts Registry of Motor Vehicles (RMV) should have a role in the transition to mobility options, 57% of respondents expressed that they believe that there is a role for the RMV in terms of assisting drivers with the transition to alternative transportation. Furthermore, respondents were asked which interventions should be integrated within the licensing authority regarding transportation alternatives. Eighty-seven percent were in favor of providing information on volunteer driver programs; 87% were in favor of public transportation discount cards; 83% were in favor of providing information on driving cessation counseling/support groups; and 83% were in favor of providing brochures on local transportation alternatives. Other suggested interventions were expansion of alternative transportation, public education, local television advertisements, and Triad programs.

Conclusions

The stakeholders included in this study believe that Massachusetts is ready for a change related to licensing and renewal practices as well as to the medical review of impaired drivers. In fact, a majority of the respondents disagreed with many of the current practices discussed in the interviews. A notable exception is the resounding agreement for continuing the voluntary reporting practice. There were several issues identified that evoked strong opinions from respondents, while it was revealed that more evidence-based data are needed on other issues to formulate opinions and recommendations.

Most of the respondents disagreed with current practices regarding the lack of immunity for reporting, in good faith, potentially unsafe drivers. Specifically, it was the consensus that physicians should be granted immunity for reporting medically at-risk drivers. Also, there was support for other allied health care professionals receiving immunity for reporting medically at-risk drivers. However, family members were viewed differently from the other presented options, in that this group received much less support, and may warrant further discussion.

Over half of all respondents also disagreed with the current reporting practice that does *not* ensure confidentiality for reporters. Among those professionals that respondents

supported to receive confidentiality are physicians and other allied health professionals, including optometrists/ophthalmologists, and occupational therapists. As with the issue of immunity for reporters, there was less support for ensuring confidentiality for family members as well.

An issue at the forefront of policy discussion in Massachusetts recently is licensing renewal practices. Based on this debate, it is no surprise that a large majority of respondents overall did not agree with the current practice that does not include triggers for accelerated renewal. Recurring recommendations from the stakeholders included advocacy for more frequent in-person renewal, a closer scrutiny on all drivers regardless of age (a focus on function), and the inclusion of more specific closed-ended questions regarding self-reporting of medical conditions or medications that may affect critical driving skills on licensing and renewal forms (such as the checklist on Maine's license renewal form). When discussing the current vision testing practices with the respondents, one recurring sentiment was that 10 years is too long of a period for drivers to go without vision testing and that the current testing procedures could be strengthened. Moreover, instituting accelerated renewal practices received favorable responses from respondents, and though most were unsure of what should warrant accelerated renewal, many respondents stated that age alone should not be a deciding factor.

Regarding the composition and function of the Massachusetts Medical Advisory Board, respondents suggested expanding the composition to include other allied health professionals, specifically driver rehabilitation specialists/occupational therapists. Also, beyond policy advising, respondents advocated for the MAB to have a more direct role in reviewing cases, such as in Maryland. Finally, it was suggested by many that the MAB should meet on a more regular basis.

Although the majority of respondents disagreed with the current practice in Massachusetts regarding the lack of counter personnel training at the Registry of Motor Vehicles, it became apparent through the open-ended responses that respondents were unclear on the difference between screening and assessment. Assessments should only be conducted by trained professionals while screening may alert people to "red flags" that may warrant referral to specialized assessment.

Finally, an important issue when driving cessation or license revocation occurs is the transition to mobility options. There were many strong opinions on the importance and necessity for alternative mobility options; however, there was a lack of consensus in what respondents believed was the extent of the role of the RMV in contributing to the solution.

Recommendations

The reviewed literature and the interviews conducted suggest the following recommendations and areas where more discussion and research are needed:

- Grant physicians immunity for reporting, in good faith, medically at-risk drivers, and develop clear guidelines and standards for reporting.
- Strengthen the role, function, and composition of the Massachusetts Medical Advisory Board and also the function of the Registry of Motor Vehicles. Specifically, develop a training program for the RMV counter personnel to screen for medically at-risk drivers and identify “red flags” that would lead to a referral for further screening and/or assessment.
- Continue the dialogue on the other issues where recommendations for change are less clear. More discussion/research is needed to identify professionals who should be granted immunity for reporting, in good faith, at-risk drivers. Furthermore, more dialogue is needed among stakeholders, specifically on the role of informal reporters, such as friends and family, regarding both immunity and confidentiality.
- Explore the issue of accelerated renewal, emphasizing a focus on functional impairment rather than age.
- Explore the role of the RMV and larger community in driving cessation and referral to mobility options.

INTRODUCTION

Although older drivers are generally found to be safe drivers, aging often brings about functional limitations and an increase in medications that can impede safe driving and fitness to drive (Kissinger, 2008; Adler & Silverstein, 2008). An increase in age is accompanied by an increase in the prevalence of such conditions as arthritis, dementia, and macular degeneration, which may impair critical driving skills and compromise safety (Silverstein, 2008). Thus, with the aging of the Baby Boom population, there are increasing concerns around mobility issues.

Transportation is a crucial part of everyday life. Being a driver of an automobile is a highly utilized mode of transportation. In fact, driving is the main mode of travel for those aged 65 and older (Rosenbloom, 2003). Silverstein (2008) concluded that there are many stakeholders involved in the safe mobility of both individuals and the public as a whole, and also emphasized the enormity of the many issues (i.e., screening and assessment of functional impairments, licensing, renewal, restriction, and cessation) that are of potential concern to geriatricians and gerontologists.

Overall, states vary greatly in their approaches to licensing and renewal practices and in the utilization, composition, and function of Medical Advisory Boards (MAB). Specifically, the purpose of this study was to assess stakeholder opinion on current and future directions for Massachusetts in terms of strengthening MAB review and registry activities regarding medically-at-risk drivers. We focused on eight domains identified in the literature and practiced in other states, including: 1) immunity for reporters of impaired drivers, 2) mandatory versus voluntary reporting practices, 3) confidentiality for reporters, 4) renewal practices, 5) vision requirements, 6) training for Registry of Motor Vehicles counter personnel, 7) MAB role, composition, and activities, and 8) transition to mobility options. For many of these domains, there is not yet clear evidence that crash risk is reduced and public safety increased. Thus, seeking the opinions of the stakeholders most closely involved with these issues, many of whom have formed their opinions based on their clinical practice experiences, seemed appropriate for framing the issues for Massachusetts and beginning the dialogue for where there appears to be agreement with current practice, where current practice is challenged, and where issues are acknowledged but more evidence-based data are needed.

BACKGROUND

The area of research regarding medical review of impaired drivers and fitness to drive is rich with literature; however, there is a lack of consensus on what policies and practices are most effective for each state. During the course of a two-semester Aging and Social Policy seminar, gerontology students became immersed in much of the traffic safety literature and explored the varying practices and policies of each state. The following review of the literature provides a summary of varying state approaches to the challenge of maintaining safe mobility. This review was critical in the planning and development of this study.

Immunity for Reporters

Currently, there is no immunity for physician reporting of at-risk drivers in Massachusetts; however, over half of all states do provide some form of immunity to physicians for reporting (Wang, Kosinski, Schwartzberg, & Shanklin, 2003). Without immunity, legal action could result against the reporter in two ways: 1.) Failure to report when a medical condition may affect critical driving skills and the patient is involved in a motor vehicle crash or, 2.) Reporting a patient as an at-risk driver when he or she does not agree with the assessment.

Mandatory versus Voluntary Reporting by Physicians

Mandatory reporting for physicians related to specific medical conditions that may affect critical driving skills currently exists in six states (California, Delaware, New Jersey, Pennsylvania, Nevada, and Oregon), while the other 44 states, including Massachusetts, practice voluntary reporting (Meuser & Carr, 2008). Under the mandatory medical reporting laws in states such as California, Delaware and Nevada, physicians are required to report patients with specific medical conditions to the proper authorities. In the other states, including Pennsylvania, mandatory reporting laws more broadly state that physicians are required to report “unsafe” drivers (Wang, Kosinski, Schwartzberg, & Shanklin, 2003).

Confidentiality for Reporting

In Massachusetts, those who report at-risk drivers are not granted confidentiality (Wang, Kosinski, Schwartzberg, & Shanklin, 2003). However, other states, such as Missouri, provide confidentiality for all reporters including health professionals, family members, and law enforcement officers (Meuser & Carr, 2008). Further, Meuser and Carr assert that in states that lack confidentiality or civil immunity protection, physicians may have compelling rationale to avoid submitting a report since both physician and patient could experience negative consequences.

Licensing and Renewal Practices

Studies have demonstrated that in-person renewal is the most significant factor in reducing crash fatalities (Classen et al., 2007; Grabowski, Campbell, & Morrissey, 2004). In Massachusetts, license renewal is required every five years, with in-person renewal required every ten years. Specifically, Internet renewal is allowed every other renewal

period, thus an individual may go 10 years without a vision test. Vision is a critical factor in assuring safe driving and will be discussed later in this section.

Another factor utilized in assuring safe driving is the reporting of medical conditions and medications that may impair critical driving skills. Currently, the licensing renewal form for Massachusetts (Appendix A) asks drivers to self-report if they: 1.) have a medical condition that may interfere with safe driving or, 2.) take medication that may interfere with safe driving. Drivers who answer “yes” must provide certification from a medical professional that they are “safe to operate.” This practice implies that the driver will recall all medical conditions and medications and is able to self-assess whether these conditions and medications will have an impact on safe driving. Other states, such as Maine, provide a checklist of specific medical conditions known to have an impact on critical driving skills (Appendix B).

There is also variation among states regarding accelerated renewal (shortened renewal periods). Currently, Massachusetts law does not have accelerated renewal provisions (*Licensing renewal provisions for older drivers*, 2009). Some states, such as Illinois, Hawaii, Florida, Iowa, and Indiana, have accelerated renewal for drivers based on specific factors such as crash history, citations/infractions, medical conditions, medical certification of driver fitness, and age (Lococo, 2003).

Massachusetts, which enforces a law that forbids age discrimination in licensing policies, ranks in the highest half of accidents per drivers ages 65 and over (Brinig, 2007). Other states do require additional testing triggered by age. In New Hampshire and Illinois, a road test is required at age 75 (*Licensing renewal provisions for older drivers*, 2009). Vision testing is required in Florida for those ages 80 and older at each renewal [below age 80, drivers may go up to 18 years without a vision test] (Lococo, 2003). Moreover, Lococo (2003) notes that the District of Columbia requires drivers ages 70 and above to obtain a physician’s signature for each subsequent renewal, signifying that the physician has examined the applicant and found him or her to be “mentally and physically competent to operate a motor vehicle safely” (p.67). The District of Columbia also requires a vision test, and possibly a reaction test (not strictly enforced), at each renewal for drivers ages 70 and older (Lococo, 2003).

A medical condition such as dementia can impair critical driving skills. In fact, a study by Meuser, Carr, and Ulfarsson (2009) found that the total traffic crash involvement of drivers reported under Missouri’s voluntary reporting law (see Appendix C) during the period 2001-2005 (dementia was the most commonly reported medical condition) was four times higher than the control group. Studies have also shown that about 30% of persons with dementia continue driving (Carr et al., 2006; Duchek et al., 2003) for up to three to five years post diagnosis (Lucas-Blaustein, Filipp, Duncan, & Tune, 1988; Fox, Bowden, Bashford, & Smith, 1997; Bédard, Molloy, & Lever, 1998). Drivers with dementia who have undergone specialized driving assessment by certified driver rehabilitation specialists (CDRS) and have been told that they are fit to drive are also told to return for periodic re-examination. Currently, Massachusetts does not have policies that specifically address the licensing renewal process for drivers with dementia.

Vision Requirements

Vision is a critical factor in assuring safe driving. The National Highway Traffic Safety Administration (NHTSA) reported that conditions such as cataract, glaucoma, increased sensitivity to glare, macular degeneration, and decreased ability to focus on static and dynamic objects all affect critical driving skills (Dobbs, 2005). Furthermore, vision begins to deteriorate at around age 40 (Carr, 2008). Given current licensing renewal policies in Massachusetts, it is possible to go without a vision test for 10 years. Moreover, the current emphasis on vision testing for licensing and renewal has been on visual acuity, while the research literature suggests that contrast sensitivity and visual processing appear to be more relevant for detecting road hazards, gap judgment, lane keeping, stopping judgment, and at-fault safety errors (Wood, 2002; Wood, 2006; Uc, Rizzo, Anderson, Shi, & Dawson, 2004).

Some tests that are currently administered should be reconsidered. For example, Massachusetts currently requires that individuals have color vision for red, green, and amber in order to obtain a driver's license. Very few states, if any, require color recognition, since individuals are able to distinguish differences in contrast and intensity of traffic lights.

Registry of Motor Vehicles Counter Personnel Training

Currently in Massachusetts, counter personnel do not receive specialized training in screening for at-risk drivers. In Missouri, counter personnel at the Department of Motor Vehicles and Driver Licensing do receive such training. That Department issues two guides for field and central office staff, "Evaluating Driving Impairments" and "Training Guide for Reporting Driver Impairments," to use in evaluating and reporting driving impairments (Lococo, 2003). Lococo stated that, "These guides provide examples of what to look for, what kinds of questions to ask to gather more information from the applicant, and how to record detailed and unbiased documentation of observed physical and mental abilities" (p.186). Motor Vehicle department employees may then submit a Driver Condition Report to the Customer Assistance Bureau (Lococo, 2003).

Medical Advisory Boards

Medical Advisory Boards vary greatly from state to state in terms of composition, function, and impact related to the assessment of impaired drivers. The MAB in Massachusetts serves largely as a policy advisory board. Their responsibility is to make recommendations to the Registrar regarding minimum medical standards for driver licensing, standards for disabled parking, and licensing policy concerning medical issues. The composition of the Medical Advisory Board is defined by Massachusetts law. There are 15 voting members, all voluntary, including 13 physicians, one chiropractor, and one optometrist. The physicians' proficiencies include ophthalmology, cardiology, neurology, endocrinology, rheumatology, otology and psychiatry. There are three physicians who specialize in geriatric medicine. The Board is chaired by a person appointed by the Department of Public Health. The review of impaired driving reports is largely done by the Medical Review unit of the Registry of Motor Vehicles. The MAB reviews approximately 10 special cases per year (Evans, 2008).

In other states, MABs have a more direct responsibility in reviewing impaired driving reports. The Maryland Medical Advisory Board conducts such activities as reviewing and advising on individual cases by performing paper reviews; conducting in-person or video interviews with a small number of referred drivers; screening and assessing referred drivers to assess whether they possess the visual abilities to drive safely; advising on vision standards and medical criteria for licensing; developing uniform, medically acceptable report forms; developing educational materials for the general public on driver impairment; recommending training courses for driver license examiners in medical/functional aspects of fitness to drive; informing the Licensing Agency of new research on medical fitness to drive; conducting or overseeing new research; and advising on procedures and guidelines (Lococo, 2003).

Transition to Mobility Options

For people age 65 and older in the United States, driving an automobile is the main mode of transportation (Gantz, 2002). Foley, Heimovitz, Guralnik, and Brock (2002) estimate that over 600,000 individuals aged 70 and older stop driving each year. If an individual can no longer drive and cannot use public transportation, the lack of community mobility options can lead to isolation and depression (Nahid et al., 2002).

Due to driving cessation, older adult men on average will need seven years of transportation support, while women will need approximately ten years (Dickerson et al., 2007). Presently, less than 10% of older persons use public transportation at least once a month (Bailey, 2004). This is, in part, because many forms of public transportation are not “senior friendly.” To determine whether alternative transportation services are senior friendly, research by the Beverly Foundation has identified five attributes upon which to focus: availability, acceptability, accessibility, adaptability, and affordability (Dickerson et al., 2007). Thus, there are many factors to consider when addressing this transition to alternative mobility options.

METHODOLOGY

This study was conducted under the auspices of an Aging and Social Policy Capstone Seminar at the University of Massachusetts Boston, College of Public and Community Service, during Spring 2009. Student researchers planned, developed, and executed the study under the supervision of Professor Nina Silverstein and gerontology doctoral student, Kelli Barton, who served as the teaching assistant. The project was approved by the University of Massachusetts Boston Institutional Review Board (IRB) as required for the protection of human subjects prior to data collection.

Recruitment

The participants included in this study were purposively chosen because of their expertise and involvement in issues related to senior transportation. Some were members of the *Safe Roads Now* coalition, a group of individuals from such organizations as AARP Massachusetts, Alzheimer’s Association Massachusetts/New Hampshire Chapter, Massachusetts Medical Society, and Senior Mobility Initiative on Cape Cod. These individuals had previously participated in drafting an outline for state legislators in May

2008 of suggestions and initiatives for making roads safer for all drivers. This document proposed 13 overarching components to be incorporated into a redrafted version of previously proposed bills before the Massachusetts legislature. The components included in-person license renewal, implementation of a tiered testing/assessment system, the voluntary reporting of health care providers, and reporting immunity. Other participants were recruited from among attendees at a Fall 2008 conference held at UMass Boston on relevant issues titled *Global Approaches to Licensing and Older Driver Safety and Mobility*. In addition, representatives from the state legislature, the licensing authority, advocacy organizations, and law enforcement were interviewed. “Snowball” sampling was utilized, based on recommendations from initial contacts. Once possible participants had been contacted via an introductory email from either the *Safe Roads Now Coalition* or Professor Silverstein, they were then contacted by a student researcher to schedule an interview.

Data Collection

The survey topics included immunity for reporting, mandatory versus voluntary reporting practices, confidentiality for reporters, licensing and renewal practices, vision requirements, medical advisory boards, transition to mobility options, and Registry of Motor Vehicles counter personnel training. For each of these categories, both closed- and open-ended questions were included.

Two students participated in each interview to ensure that interviews were conducted in a uniform manner and that all of the questions and elements were addressed. Furthermore, a script was created for each pair of students to keep the interview structured and consistent. The intent was for all interviews to be in-person. However, due to geographic and scheduling constraints, two interviews were conducted by telephone. Also, with the consent of the interviewees, sessions were recorded with a digital voice recorder that allowed researchers to extract data from the interviews. The format of the interview was to present an issue, describe some background from the literature, and then present the questions on that issue.

Data Analysis

Each research team was responsible for transcribing the qualitative portion of the interviews they conducted. The transcripts from all research pairs were compiled into one master electronic file and disseminated to the entire research team for further analysis as part of the learning process for the research seminar. The closed-ended responses were entered into the data analysis program SPSS to attain frequency tables for the responses.

RESULTS

Sample Description

The respondents included stakeholders in driver safety, with representatives from the state legislature, government agencies, advocacy organizations, the licensing authority, medical communities, driving assessment centers, mobility planners, academic communities, and law enforcement. Of the 44 stakeholders identified, 17 declined

participation or designated an alternate; three did not respond to recruitment strategies; one had a scheduling conflict; and 23 completed the interview (52% response rate).

The results are presented by categories discussed during the interviews. Within these categories, the question is presented along with totaled responses to the closed-ended questions and selected excerpts from the open-ended questions.

Figure 1. Immunity for Reporters

“I like this question because you pull out both weaknesses. Physicians are damned if they do and damned if they don’t. If they report, they can get sued. If they don’t, they can get sued...”

–Academic Researcher

“Missouri law (HB-1536) should be a model for everyone else.”

–Traffic Safety Organization

“I think immunity would give a lot of physicians and medical personnel more comfort in reporting people to the medical advisory board that should be reported, without fear of any personal or professional consequences. I think it would be a wonderful tool.”

–Legislator/Legal Aide

Immunity for Reporters

After respondents were given information regarding the current status of immunity for reporters in Massachusetts and in other states, they were asked: *“Which of the following statements best describes your view on the current practices in Massachusetts regarding immunity for physician reporting?”* Almost all respondents (91%) stated that Massachusetts should provide immunity to physicians who, in good faith, report patients to the licensing authority whom they consider at-risk for unsafe driving.

Figure 1 captures some of the respondents’ responses when asked for additional comment.

Respondents were then asked if any others should be granted immunity for reporting at-risk drivers to the licensing authority. They were asked specifically about the following categories: optometrist/ophthalmologist (78%); nurses (70%); occupational therapists (65%); social workers (57%); other allied health professionals (52%); and family (26%). Other suggestions included firefighters, psychologists/psychiatrists, neurologists, and Council on Aging staff members.

Mandatory versus Voluntary Reporting Practices by Physicians

The next section asked respondents their opinions on mandatory versus voluntary reporting practices by physicians. Fifty-six percent agreed with current practices of voluntary reporting in Massachusetts, while 9% had mixed opinions. One participant stated, *“I think that [the] voluntary or mandatory issue needs to be looked at. While I don’t know whether it’s an either or, Massachusetts should be voluntary or mandatory, I think we should [be] reviewing that because for someone to be an unsafe driver and for someone to report them need[s] to be better defined in Massachusetts”* (Advocacy Group). Another respondent stated, *“I think our current practice would be strengthened by giving physicians immunity along with voluntary reporting. I think immunity along with voluntary reporting is sufficient”* (Legislator/Legal Aide).

Confidentiality for Reporting

When asked about their views on the current practice in Massachusetts that does not grant confidentiality for reporters, 65% of respondents did not agree with this practice, while 4% had no opinion. The results when respondents were asked who should be ensured confidentiality from a given list of professionals were: other allied health professionals (52%); optometrists/ophthalmologists (48%); occupational therapists (44%); social workers (39%); and family (30%). Other professionals suggested by the respondents to be ensured confidentiality were police officers, neighbors, and friends. One respondent added, *“People will be more likely to report if there is confidentiality”* (Legislator/Legal Aide).

Licensing and Renewal Policies

Eighty-three percent of the 23 respondents did not agree with the current licensing renewal practice in Massachusetts discussed in the Background section of this report (p.2). One response to the open-ended portion of this question that is representative of statements from other respondents states, *“Everyone should be tested. It’s not a function of old age. In-person renewal is more effective”* (Medical Professional).

As previously mentioned, the current licensing renewal form for Massachusetts asks drivers to report if they have medical conditions or take medications that may interfere with safe driving, but it does not ask about specific conditions or medication (see Appendix A). Respondents were asked if they agreed with these current practices regarding self-reporting of medical conditions: 61% did not agree, while 4% had no opinion on the issue. Some of the responses given include: *“No, the checklist would be a better idea, should be more than [an] open-ended question...”* (Advocacy Group) and *“It is not the individual’s role to reveal what their limitations are, but the system should identify. The form is impossible to fill out, it is confusing and terrible”* (Advocacy Group).

When asked their opinions on the current licensing renewal practice in Massachusetts regarding the lack of an accelerated renewal provision, 61% did not agree with current practices; 17% had no opinion on the issue; 13% agreed; and 9% had mixed opinions. Those who reported that they did not agree (14 respondents) were then asked which factors they thought might warrant accelerated renewal: 57% were in favor of using an individual’s crash history; 39% were in favor of using a record of citations/infractions history; 35% were in favor of using medical conditions; 30% were in favor of medical certification of driver fitness; and only 22% were in favor of age as a factor in triggering accelerated renewal. Furthermore, all respondents were asked if they agree with current practices specifically in Massachusetts prohibiting age-triggered testing. Over half of all respondents (57%) agreed with continuing the current practice of prohibiting age-triggered testing, while 4% had no opinion on the issue. Figure 2 includes some comments that are representative of other respondents’ statements.

Figure 2. Age-Triggered Testing

“Mixed on the issue due to the physical and age limitations. A number does not tell us much. There are more pieces to this...” -Medical Professional

“No, accelerated renewal is a good idea. One item on the list that should not be is ‘age.’ The decision should be on objective criteria such as excessive violations, etc. Age is not the answer and is discriminatory. We want people to be screened on abilities not age.” -Medical Professional

Vision Requirements

The next section of the interview discussed vision requirements and asked respondents if they agree with the current licensing renewal policies that potentially allow drivers to go without a vision test for 10 years. Of the total 23 respondents, 20 disagreed with the current practices, while one respondent did not offer an opinion on the issue. One participant provided the additional comment:

I think ten years is too long. I don’t know what the right number would be but certainly ten years after the age of 40 or 50 is too long and the current vision screening that they do is ridiculous. I mean it’s just a joke. If you don’t know the letter, the lady tells you the letter because she doesn’t want to fail anybody...It’s not the most objective screening. So I think that screeners need training, especially around older drivers. [Screeners] need to understand that if [they] pass somebody because [she is] old and cute...that’s not helping public safety and public health issues of the older driver (Social Worker).

Another issue discussed in the interview was the provision in Massachusetts that requires individuals to have color vision for red, green, and amber in order to obtain a driver’s license. Fifty-two percent of respondents had no opinion on the issue, while 26% disagreed and 22% agreed. Three responses received in regards to this question are: “...have not really thought about it” (Academic Researcher), “...unaware that that was the law” (Advocacy Group), and “It is irrelevant. There are many more important things to consider than color vision” (Academic Researcher).

Registry of Motor Vehicles Counter Personnel Training

The next issue discussed with respondents was whether or not there was a need for specialized training of licensing authority counter personnel to recognize “red flags” or indicators where an applicant for licensing or renewal should be referred for further assessment.¹ Sixty-one percent disagreed with the current practice in Massachusetts that

¹ It is important to note the difference between screening and assessment since it is commonly misunderstood. Screening is informal and may then lead to more in-depth diagnostic assessments to determine the etiology, extent, and implications for the observed functional impairment (Dickerson et al., 2007). Furthermore, the result of a functional screening tool does not support a decision to stop driving, and instead, “...may provide valuable information to be considered by a qualified professional in a fitness-to-drive evaluation, or it may serve as a trigger for further evaluation” (Dickerson et al., 2007, p.580).

does not provide training to Registry of Motor Vehicles (RMV) counter personnel (13% had no opinion on the issue).

Figure 3. RMV Counter Personnel Training

“I don’t think the [RMV] counter is the place where the evaluation should be made. They should be competent for the job, but I don’t think that’s their job. I do think that people need screening.”–Advocacy Group

“It is unfair to let the person know [that a license is revoked] at the counter...”–Advocacy Group

A few additional comments made by respondents are shown in Figure 3.

Medical Advisory Board

After being presented with information on the composition, function, and current practices of the Massachusetts Medical

Advisory Board, as well as advisory boards in other states, respondents were asked their opinions on these issues. When asked about the current practices specifically related to the Massachusetts MAB, 78% disagreed with these practices, while 13% had no opinion. In regards to the composition of the Massachusetts MAB, 87% were not satisfied with the current composition. Respondents who indicated that they were not satisfied with the current composition (20 respondents) were then asked which professionals should be considered for appointment to the Massachusetts MAB. Sixty-five percent were in favor of a certified driver rehabilitation specialist/occupational therapist, 50% were in favor of including a geriatrician, and 45% were in favor of including a gerontologist. Other professionals that were suggested include psychiatrist/psychologist, neurologist, neuropsychologist, optometrist/ophthalmologist, vision therapist, specialized physician, legal representative, and nurse.

Finally, 87% of respondents reported that they were not satisfied with the current function of the MAB. Of these (20 respondents), 60% recommended meeting on a regular basis as a way to strengthen the Massachusetts MAB; 55% supported a more direct involvement with review; and 30% supported a change from the current voluntary status to offering a stipend or honorarium. One respondent stated:

Now, I believe that the medical review board in Massachusetts is similar to the professional review board of Massachusetts and they’re a policy-making board. So I guess if you were thinking of strengthening the medical review board you would want to look at strengthening the rest of the board. As a policy person, I would be much more interested in this broader view rather than specifically the medical review board (Advocacy Group).

Transition to Mobility Options

When asked whether the Massachusetts Registry of Motor Vehicles should have a role in the transition to mobility options, 57% of respondents expressed that they believe that there is a role for the RMV in terms of assisting drivers with the transition to alternative transportation. Figure 4 displays additional comments of some of the respondents. Furthermore, respondents were asked which interventions should be integrated within the licensing authority regarding transportation alternatives. Eighty-seven percent were in favor of providing information on volunteer driver programs; 87%

were in favor of public transportation discount cards; 83% were in favor of providing information on driving cessation counseling/support groups; and 83% were in favor of providing brochures on local transportation alternatives. Other suggested interventions that were expressed in the open-ended response portion of this section include expansion of alternative transportation, public education, local television advertisements, and triad programs.

Figure 4. Transition to Mobility Options

“The Registry’s got too much on their plate right now but I think social service agencies and certainly agencies on aging and senior home care agencies need to create more interesting [and] creative options than The Ride.” –Social Worker

“[The] Registry should have a formalized program that starts before the driver’s license is suspended or taken away.” –Advocacy Group

“...to saddle (the RMV) with one more thing is a bit unfair...I think it’s something that has fallen through the cracks...But I totally agree...that current alternative transportation resources are slim and most older people find the ‘T’ difficult.” –Medical Professional

“...I think communities...non-profit corporations...[and] family and friends can do that...Public transportation is not the answer. Particularly [for] the two-thirds of the country where the people don’t live near it.” –Advocacy Group

CONCLUSIONS

The stakeholders included in this study believe that Massachusetts is ready for a change related to licensing and renewal practices as well as to the medical review of impaired drivers. In fact, a majority of the respondents disagreed with many of the current practices discussed in the interviews. A notable exception is the resounding agreement for continuing the voluntary reporting practice. There were several issues identified that evoked strong opinions from respondents, while it was revealed that more evidence-based data are needed on other issues to formulate opinions and recommendations.

Most of the respondents disagreed with current practices regarding the lack of immunity for reporting, in good faith, potentially unsafe drivers. Specifically, it was the consensus that physicians should be granted immunity for reporting medically at-risk drivers. Also, there was support for other allied health care professionals receiving immunity for reporting medically at-risk drivers. However, family members were viewed differently from the other presented options, in that this group received much less support, and may warrant further discussion.

Over half of all respondents also disagreed with the current reporting practice that does *not* ensure confidentiality for reporters. Among those professionals that respondents

supported to receive confidentiality are physicians and other allied health professionals, including optometrists/ophthalmologists, and occupational therapists. As with the issue of immunity for reporters, there was less support for ensuring confidentiality for family members as well. While some respondents expressed the opinion that individuals who have been reported have a right to know who reported them, others believed that this may serve as a deterrent for potential reporters, especially those closest to the individual (i.e. family).

When discussing the current vision testing practices with the respondents, one recurring sentiment was that 10 years is too long of a period for drivers to go without vision testing and that the current testing procedures could be strengthened. However, the majority of respondents did not have an opinion on the current color vision practices. Many reported that they had not thought about this issue enough to form an opinion, were unaware of this requirement, and that the issue is irrelevant since there are bigger issues on which to focus.

An issue at the forefront of policy discussion in Massachusetts recently is licensing renewal practices. Based on this debate, it is no surprise that a large majority of respondents overall did not agree with the current practices. Recurring recommendations from the stakeholders included advocacy for more frequent in-person renewal, a closer scrutiny on all drivers regardless of age (a focus on function), and the inclusion of more specific closed-ended questions regarding self-reporting of medical conditions or medications that may affect critical driving skills on licensing and renewal forms (such as the checklist on Maine's license renewal form). Moreover, instituting accelerated renewal practices received favorable responses from respondents, and though most were unsure of what should warrant accelerated renewal, many respondents stated that age alone should not be a deciding factor.

Regarding the composition and function of the Massachusetts Medical Advisory Board (MAB), respondents suggested expanding the composition to include other allied health professionals, specifically driver rehabilitation specialists/occupational therapists. Also, beyond policy advising, respondents advocated for the MAB to have a more direct role in reviewing cases, such as in Maryland. Finally, it was suggested by many that the MAB meet on a more regular basis.

Although the majority of respondents disagreed with the current practice in Massachusetts regarding the lack of counter personnel training at the Registry of Motor Vehicles, it became apparent through the open-ended responses that respondents were unclear on the difference between screening and assessment. (This issue is described in Footnote 1).

Finally, an important issue when driving cessation or license revocation occurs is the transition to mobility options. There were many strong opinions on the importance and necessity for alternative mobility options; however, there was a lack of consensus in what respondents believed was the extent of the role of the RMV in contributing to the solution.

RECOMMENDATIONS

The reviewed literature and the interviews conducted suggest the following recommendations and areas where more discussion and research are needed:

- Grant physicians immunity for reporting, in good faith, medically at-risk drivers, and develop clear guidelines and standards for reporting.
- Strengthen the role, function, and composition of the Massachusetts Medical Advisory Board and also the function of the Registry of Motor Vehicles. Specifically, develop a training program for the RMV counter personnel to screen for medically at-risk drivers and identify “red flags” that would lead to a referral for further screening and/or assessment.
- Continue the dialogue on the other issues where recommendations for change are less clear. More discussion/research is needed to identify professionals who should be granted immunity for reporting, in good faith, at-risk drivers. Furthermore, more dialogue is needed among stakeholders, specifically on the role of informal reporters, such as friends and family, regarding both immunity and confidentiality.
- Explore the issue of accelerated renewal, emphasizing a focus on functional impairment rather than age.
- Explore the role of the RMV and larger community in driving cessation and referral to mobility options.

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Appendix A



Massachusetts Registry of Motor Vehicles License/ID Update Application

☐ Change of Information
☐ License Issue

Check appropriate box:
☐ Duplicate: (Check one) ☐ License ☐ Permit ☐ Mass ID ☐ Liquor ID
☐ Reinstatement ☐ Renewal: (Check one) ☐ License ☐ Mass ID

License Class Applying For: ☐ A ☐ B ☐ C ☐ D ☐ M	CDL Endorsements Applying For: (For Class A, B, OR C) ☐ AIR BRAKES ☐ COMBO ☐ HAZMAT ☐ PASSENGER ☐ TANK ☐ DOUBLES/TRIPLES ☐ SCHOOL BUS
Fees are payable by Cash, Check, Money Order, Mastercard, Visa, or Discover. If paying by check, please make payable to "Registry of Motor Vehicles" or "RMV".	
Identification Requirements For certain transactions, applicants over the age of 18 must present three forms of ID which include: • Proof of date of birth • Proof of signature • Proof of Massachusetts residency Applicants under 18 years of age must only provide proof of date of birth. The parent/guardian must sign the certification at bottom. You must also produce your social security number (SSN) that the RMV can verify with the U.S. Social Security Administration (SSA) as having been issued to you. If you do not have an SSN, an acceptable written denial notice not more than 30 days old, from the Social Security Administration (SSA) is required. You must also provide proof of an acceptable visa status, an I-94, and a current non-U.S. Passport.	
Please see the Driver's Manual for the identification requirements you must satisfy to obtain a license or ID and the list of "Acceptable Forms of Identification" that may satisfy those requirements. The list is also on our website at www.mass.gov/rmv .	

General Applicant Information Please print neatly with a ball point pen in blue or black ink.				
Social Security Number (SSN): _____			MA assigned License/Permit/ID Number: _____	
If you currently use your SSN as your license/permit/ID number, the RMV will automatically issue you a state assigned number. Federal Law prohibits use of your SSN on a License/Permit/ID.				
Name: Last _____ First _____ Middle _____		Sex: ☐ M ☐ F	Date of Birth (month/day/year) _____	
Residential Address: (Where you actually reside)				
Street# _____	Apt/Unit# _____	City _____	State _____	Zip Code _____
Mail Address: (Where you want us to send your Driver's License/ID and future notices from the RMV) U.S. Post Office MAY NOT deliver if your name is NOT on the mailbox.				
Street# _____	Apt/Unit# _____	City _____	State _____	Zip Code _____

Change of Information (Leave this section blank if no changes)

☐ Check here if your name has changed. Please print your new name in the General Information section and your previous name below.
 Previous Name: (Last, First, Middle) _____

☐ Check here if the address in the General Information section reflects a change of **Mailing Address**.

☐ Check here if the address in the General Information section reflects a change of **Residential Address**.

☐ Check here if height has changed. Current height is ft. ____ in. ____

☐ Check here if gender designation has changed. **Note: additional documentation will be required.**
 Change Gender Designation to: ☐ Male ☐ Female

REQUIRED INFORMATION			to be completed by all applicants
1. Are you currently licensed to drive in any state, the District of Columbia, or a foreign country? ☐ Yes ☐ No If yes, where? _____ What Class or type of license? _____ 2. In the past 10 years have you held any class of driver's license in any <u>other</u> state, the District of Columbia, or a foreign country? ☐ Yes ☐ No If yes, where? _____ License Class _____ License # _____ _____ _____ (Inform RMV of previous names) (Use additional paper if you need more space) 3. Do you want to be, or continue to be, an organ or tissue donor? ☐ Yes If yes, the RMV will print the designation on your driver's license/ID. Applicants under age 18 need consent from a parent/guardian. Parent/Guardian Certification: I hereby certify that I give permission for the applicant named above to register as an organ or tissue donor. _____ Parent/Guardian Signature	4. Is your license or RIGHT to operate suspended, revoked, canceled, withdrawn, or disqualified here or in any other state? ☐ Yes ☐ No If yes, where? _____ Exp. Date _____ If yes, why? _____ 5. Are you an active duty member of the U.S. armed forces? ☐ Yes ☐ No 6. Do you have any medical condition that may affect your ability to safely operate a motor vehicle? ☐ Yes ☐ No (The Medical Advisory Board has established standards to determine fitness to operate a motor vehicle. Ask a clerk for a summary of these standards or visit our website at www.mass.gov/rmv for the complete list of these standards.) 7. Are you currently taking any medication that may affect your ability to safely operate a motor vehicle? ☐ Yes ☐ No Note: If you answered yes to questions 4, 6, or 7, additional documentation may be required.		
The RMV is required by law to provide certain information identifying organ donors to federally-designated organ procurement organizations and other federally registered non-profit eye and tissue banks serving the Commonwealth.			
Date: _____ Initial: _____ Vision: Pass ☐ Fail ☐		(RMV USE ONLY) Cash ☐ Credit Card ☐ Payment Type: Check ☐ Money Order ☐	
		Batch Number: _____	

- Please complete **REQUIRED Voter Registration and SIGNATURE Section** on reverse side-

T21053-0508

Appendix B

NON-COMMERCIAL CLASS C APPLICATION

NOT FOR CDL CLASS A, B or C OPERATORS PERMITS, LICENSES OR WAIVERS

Written Examination Fee Must Be Mailed With This Application.

PRINT	FIRST NAME INITIAL LAST NAME					MAILING ADDRESS	
PLACE OF RESIDENCE							
Date of Birth	Hair Color	Color of Eyes	Height	Weight	Sex	Telephone Number	Social Security Number
Month Day Year	Optional		Feet Inches	Pounds	M or F		(REQUIRED)

☐ **Class C** ***APPLICANT MUST BE AT LEAST FIFTEEN YEARS OF AGE***

\$10.00

*Basic License for operation of passenger cars and light trucks.

*Applicants fifteen years of age may hold an instruction permit, you may not apply for a road test until attaining your sixteenth birthday.

*All applicants under the age of eighteen must file a DRIVER'S EDUCATION COMPLETION CERTIFICATE.

*Anyone under the age of twenty-one must hold a permit for at least six months before applying for a road test.

*The road test phase of the examination for a license may be waived for holders of a VALID out of state license.

☐ **Oral Examination:** **If you require an oral examination you must bring your own reader/translator at time of test.**
(Check box if required) *(American Sign Language interpreters will be provided by the Bureau of Motor Vehicles upon advance request)*

●————→ PLEASE ANSWER THE FOLLOWING QUESTIONS ←————●

1) Place of birth	YES	NO
City or Town		
State or Country		
2) Are you applying for an instruction permit examination?	☐	☐
3) Have you completed a course in Driver's Education?	☐	☐
4) Do you hold or have you ever held a valid driver's license from Maine or any other state, country or province; Class:		
Expiration date:		
Where:	☐	☐
5) Have you ever held a Maine instruction permit or Non-driver identification card?		
If yes, under what name? (Print)	☐	☐
6) Have you been convicted of violating any motor vehicle laws within the last ten years?		
What was the violation	☐	☐
Date:		
Where:		
7) Is your privilege to operate a motor vehicle under suspension or revocation in this state or any other state or province?	☐	☐
8) Do you have any of the following medical conditions?	☐	
☐ Epilepsy/Seizures	☐ Paralysis	
☐ Diabetes	☐ Stroke/Shock	
☐ Heart Trouble	☐ Parkinson's Disease	
☐ Blackouts/Loss of Consciousness	☐ Mental/Emotional	
☐ Limb Amputation	☐ Other, Please Explain:	

LEGAL SIGNATURE:	DATE
No Nicknames	

Under 18 Requires...

SIGNATURE OF PARENT OR GUARDIAN

RELATIONSHIP:

MVE-64 REVISED 9/08

PLEASE READ OTHER SIDE...

Appendix C

SECOND REGULAR SESSION
(TRULY AGREED TO AND FINALLY PASSES)
SENATE COMMITTEE SUBSITITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 1536
89TH GENERAL ASSEMBLY 1998
AN ACT

To repeal sections 302.291 and 302.292, RSMo 1994, and to enact in lieu thereof two new sections relating to the reporting and examination of impaired drivers, with penalty provisions and an effective date.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 302.291 and 302.292, RSMo 1994, are repealed and two new sections enacted in lieu thereof to be known as sections 302.291 and 302.292, to read as follows:

302.291.

1. The director, having good cause to believe that an operator is incompetent or unqualified to retain his license, after giving ten days' notice to such person in writing by [registered] certified mail directed to his present known address may require him to submit to an examination as prescribed by the director. Upon conclusion of the examination, the director may allow the licensee to retain his license, may suspend, deny or revoke the license of the licensee, or may issue to the examinee a license subject to restrictions as provided in section 302.30 I. If an examination indicates a condition that potentially impairs safe driving, the director, in addition to action with respect to the license, may require the licensee to submit to further periodic examinations. The refusal or neglect of the [operator] licensee to submit to [such] an examination within thirty days after the date of such notice shall be [ground] grounds for suspension, denial or revocation of his license by the director, an associate circuit or circuit court. Notice of any suspension, denial, revocation or other restriction shall be provided by certified mail. As used in this section, the term "denial" means the act of not licensing a person who is currently suspended, revoked or otherwise not licensed to operate a motor vehicle. Denial may also include the act of withdrawing a previously issued license.

2. The examination provided for in subsection I of this section may include, but is not limited to, a written test and tests of driving skills, vision, highway sign recognition and, if appropriate, a physical and/or mental examination as provided in section 302.173.

3. The director shall have good cause to believe that an operator is incompetent or unqualified to retain his license on the basis of, but not limited to, a report by:

- (1) Any certified peace officer;
 - (2) Any physician, physical therapist or occupational therapist licensed under chapter 334, RSMo; any chiropractic physician licensed under chapter 331, RSMo; any registered nurse licensed under chapter 335, RSMo; any psychologist or social worker licensed under chapter 337, RSMo; or
 - (3) Any member of the operator's family within three degrees of consanguinity, or the operator's spouse, who has reached the age of eighteen, except that no person may report the same family member pursuant to this section more than one time during a twelve month period. The report must state that the person reasonably and in good faith believes the driver cannot safely operate a motor vehicle and must be based upon personal observation or physical evidence which shall be described in the report, or the report shall be based upon an investigation by a law enforcement officer. The report shall be a written declaration in the form prescribed by the department of revenue and shall contain the name, address, telephone number, and signature of the person making the report.
4. Any physician, physical therapist or occupational therapist licensed under chapter 334, RSMo, any chiropractor licensed under chapter 331, RSMo, any registered nurse licensed under chapter 335, RSMo, or any psychologist or social worker licensed under chapter 337, RSMo, may report to the department any patient diagnosed or assessed as having a disorder or condition that may prevent such person from safely operating a motor vehicle. Such report shall state the diagnosis or assessment and whether the condition is permanent or temporary. The existence of a physician-patient relationship shall not prevent the making of a report by such medical professionals.
5. Any person who makes a report in good faith pursuant to this section shall be immune from any civil liability that otherwise might result from making the report. Notwithstanding the provisions of chapter 610, RSMo, to the contrary, all reports made and all medical records reviewed and maintained by the department of revenue under this section shall be kept confidential except upon order of a court of competent jurisdiction or in a review of the director's action pursuant to section 302.311.
6. The department of revenue shall keep records and statistics of reports made and actions taken against driver's licenses under this section.
7. The department of revenue shall, in consultation with the medical advisory board established under section 302.292, develop a standardized form and provide guidelines for the reporting of cases and for the examination of drivers under this section. The guidelines shall be published and adopted as required for rules and regulations under chapter 536, RSMo. The department of revenue shall also adopt rules and regulations as necessary to carry out the other provisions of this section. The director of revenue shall provide health care professionals and law enforcement officers with information about the procedures authorized in this section. The guidelines and regulations implementing this section shall be in compliance with the federal Americans with Disabilities Act of

1990.

8. Any person who knowingly violates a confidentiality provision of this section or who knowingly permits or encourages the unauthorized use of a report or reporting person's name in violation of this section shall be guilty of a class A misdemeanor and shall be liable for damages which proximately result.

9. Any person who intentionally files a false report under this section shall be guilty of a class A misdemeanor and shall be liable for damages which proximately result.

10. All appeals of license revocations, suspensions, denials and restrictions shall be made as required under section 302.311 within thirty days after the receipt of the notice of revocation, suspension, denial or restriction.

11. Any individual whose condition is temporary in nature as reported pursuant to the provisions of subsection 4 of this section shall have the right to petition the director of the department of revenue for total or partial reinstatement of his or her license. Such request shall be made on a form prescribed by the department of revenue and accompanied by a statement from a health care provider with the same or similar license as the health care provider who made the initial report resulting in the limitation or loss of the driver's license. Such petition shall be decided by the director of the department of revenue within thirty days of receipt of the petition. Such decision by the director is appealable pursuant to subsection 10 of this section.

302.292.

1. In order to advise the director of revenue on medical criteria for the reporting and examination of drivers with medical impairments, a medical/vision advisory board is hereby established within the department of revenue. The board shall be composed of three members appointed by the director of the department of revenue. The members of the board shall be licensed physicians and residents of this state. Of the original appointees, one shall serve for a term of two years and two shall serve for terms of four years. Subsequent appointees shall each serve for a term of four years or until their successors are appointed and approved. Any vacancy shall be filled in the same manner as the original appointment for the remainder of the term. The members of the board shall receive no compensation for their services and shall not hire any staff personnel but shall be reimbursed for their actual and necessary expenses incurred in the performance of their official duties. After the first full year of operation of the advisory board, the board shall meet no more than four times per year.

2. No civil or criminal action shall lie against any member of the medical/vision advisory board of the department of revenue who acts in good faith in advising the department under the provisions of this chapter. Good faith shall be presumed on the part of members of the medical/vision advisory board in the absence of a showing of fraud or malice.